

		FOR OHF USE					

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH Facility ID Number: <u>0043588</u></p> <p>Facility Name: <u>LOCUSTWOOD HEALTH CARE CENTER</u></p> <p>Address: <u>3520 SCHOOL STREET</u> <u>ROCKFORD</u> <u>61101</u> Number City Zip Code</p> <p>County: <u>WINNEBAGO</u></p> <p>Telephone Number: <u>(815) 968-4280</u> Fax # <u>(815) 968-4281</u></p> <p>IDPA ID Number: <u>830320180002</u></p> <p>Date of Initial License for Current Owners: <u>02/07/98</u></p> <p>Type of Ownership:</p> <table><tr><td><input type="checkbox"/></td><td>VOLUNTARY,NON-PROFIT</td><td><input checked="" type="checkbox"/></td><td>PROPRIETARY</td><td><input type="checkbox"/></td><td>GOVERNMENTAL</td></tr><tr><td><input type="checkbox"/></td><td>Charitable Corp.</td><td><input type="checkbox"/></td><td>Individual</td><td><input type="checkbox"/></td><td>State</td></tr><tr><td><input type="checkbox"/></td><td>Trust</td><td><input type="checkbox"/></td><td>Partnership</td><td><input type="checkbox"/></td><td>County</td></tr><tr><td>IRS Exemption Code</td><td></td><td><input type="checkbox"/></td><td>Corporation</td><td><input type="checkbox"/></td><td>Other</td></tr><tr><td></td><td></td><td><input checked="" type="checkbox"/></td><td>"Sub-S" Corp.</td><td></td><td></td></tr><tr><td></td><td></td><td><input type="checkbox"/></td><td>Limited Liability Co.</td><td></td><td></td></tr><tr><td></td><td></td><td><input type="checkbox"/></td><td>Trust</td><td></td><td></td></tr><tr><td></td><td></td><td><input type="checkbox"/></td><td>Other</td><td></td><td></td></tr></table> <p>In the event there are further questions about this report, please contact: Name: <u>JEFFREY E. BOLAND</u> Telephone Number: <u>(717) 213-3125</u></p>	<input type="checkbox"/>	VOLUNTARY,NON-PROFIT	<input checked="" type="checkbox"/>	PROPRIETARY	<input type="checkbox"/>	GOVERNMENTAL	<input type="checkbox"/>	Charitable Corp.	<input type="checkbox"/>	Individual	<input type="checkbox"/>	State	<input type="checkbox"/>	Trust	<input type="checkbox"/>	Partnership	<input type="checkbox"/>	County	IRS Exemption Code		<input type="checkbox"/>	Corporation	<input type="checkbox"/>	Other			<input checked="" type="checkbox"/>	"Sub-S" Corp.					<input type="checkbox"/>	Limited Liability Co.					<input type="checkbox"/>	Trust					<input type="checkbox"/>	Other			<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/00</u> to <u>12/31/00</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table><tr><td rowspan="3">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>LARRY BONDS</u></td></tr><tr><td>(Title) <u>PRESIDENT</u></td></tr><tr><td rowspan="5">Paid Preparer</td><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td>(Print Name and Title) <u>JEFFREY E. BOLAND, DIRECTOR</u></td></tr><tr><td>(Firm Name & Address) <u>ZA CONSULTING LLC</u> <u>305 NORTH FRONT ST. HARRISBURG, PA 17101</u></td></tr><tr><td>(Telephone) <u>(717) 213-3125</u> Fax # <u>(717) 233-4633</u></td></tr><tr><td colspan="2">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</td></tr></table>	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>LARRY BONDS</u>	(Title) <u>PRESIDENT</u>	Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) <u>JEFFREY E. BOLAND, DIRECTOR</u>	(Firm Name & Address) <u>ZA CONSULTING LLC</u> <u>305 NORTH FRONT ST. HARRISBURG, PA 17101</u>	(Telephone) <u>(717) 213-3125</u> Fax # <u>(717) 233-4633</u>	MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
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Facility Name & ID Number LOCUSTWOOD HEALTH CARE CENTER

0043588 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	63	Intermediate (ICF)	63	23,058	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	63	TOTALS	63	23,058	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	16,159	1,428		17,587	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,159	1,428		17,587	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 76.27%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?
YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 2/7/98

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 2/7/98 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☐ NO ☒ If YES, enter number
of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED
CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31 Fiscal Year: 12/31

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS												
Facility Name & ID Number		LOCUSTWOOD HEALTH CARE CENTER				#	0043588	Report Period Beginning:		01/01/00	Ending: 12/31/00	
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)												
	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	97,560	6,051	5,382	108,993		108,993	(489)	108,504			1
2	Food Purchase		75,092		75,092		75,092		75,092			2
3	Housekeeping	59,822	10,906	130	70,858		70,858		70,858			3
4	Laundry	21,619	2,997	327	24,943		24,943		24,943			4
5	Heat and Other Utilities			37,413	37,413		37,413		37,413			5
6	Maintenance	27,467	2,686	15,123	45,276		45,276		45,276			6
7	Other (specify):*											7
8	TOTAL General Services	206,468	97,732	58,375	362,575		362,575	(489)	362,086			8
	B. Health Care and Programs											
9	Medical Director			3,300	3,300		3,300		3,300			9
10	Nursing and Medical Records	511,211	26,052	112,036	649,299		649,299	3,192	652,491			10
10a	Therapy			2,025	2,025		2,025		2,025			10a
11	Activities	14,981	434	1,765	17,180		17,180		17,180			11
12	Social Services	23,044		1,363	24,407		24,407	38	24,445			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	549,236	26,486	120,489	696,211		696,211	3,230	699,441			16
	C. General Administration											
17	Administrative			106,525	106,525		106,525	11,292	117,817			17
18	Directors Fees											18
19	Professional Services			1,514	1,514		1,514	22,696	24,210			19
20	Dues, Fees, Subscriptions & Promotions			13,643	13,643		13,643	(2,544)	11,099			20
21	Clerical & General Office Expenses	3,440	8,308	19,403	31,151		31,151	29,731	60,882			21
22	Employee Benefits & Payroll Taxes			66,909	66,909		66,909	49,496	116,405			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,529	5,529		5,529	2,500	8,029			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			23,969	23,969		23,969	15,111	39,080			26
27	Other (specify):*											27
28	TOTAL General Administration	3,440	8,308	237,492	249,240		249,240	128,282	377,522			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	759,144	132,526	416,356	1,308,026		1,308,026	131,023	1,439,049			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			51,090	51,090		51,090		51,090			30
31	Amortization of Pre-Op. & Org.			78,328	78,328		78,328	(73,702)	4,626			31
32	Interest			166,639	166,639		166,639		166,639			32
33	Real Estate Taxes			30,565	30,565		30,565		30,565			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			1,648	1,648		1,648		1,648			35
36	Other (specify):* Mtg. Guarantee			30,272	30,272		30,272		30,272			36
37	TOTAL Ownership			358,542	358,542		358,542	(73,702)	284,840			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		6,931	21,458	28,389		28,389		28,389			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			34,588	34,588		34,588		34,588			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		6,931	56,046	62,977		62,977		62,977			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	759,144	139,457	830,944	1,729,545		1,729,545	57,321	1,786,866			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(489)	1		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,544)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(79,513)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (82,546)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	139,867	VAR	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 139,867		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 57,321		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES				Sch, V Line
1	Amount	Reference		
1	OTHER REVENUE	\$ (40)	21	1
2	AMORT - GOODWILL	(73,702)	31	2
3	BUSINESS MEALS	(210)	21	3
4	BANK CHARGES	(92)	21	4
5	FINES/PENALTIES	(435)	21	5
6	EXTRAORDINARY ITEMS	(5,034)	21	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
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82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	Total	(79,513)		90

Summary A

12/31/00

[illegible]

Summary B

Facility Name & ID Number	LOCUSTWOOD HEALTH CARE CENTER	#	0043588	Report Period Beginning:	01/01/00	Ending:	12/31/00
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SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED LIST		SEE ATTACHED LIST		EDEN & ASSOC, INC	WILSON, WY	CONSULTING

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	10	Contract Services - RN	\$ 12,407	Senior Living Properties, LLC	100.00%	\$ 12,746	\$ 339	1
2	V	10	Contract Services - RN	38,165	Senior Living Properties, LLC	100.00%	39,469	1,304	2
3	V	10	Contract Services - RN		Senior Living Properties, LLC	100.00%	1,549	1,549	3
4	V	12	Social Services Consultant	1,363	Senior Living Properties, LLC	100.00%	1,401	38	4
5	V	17	Contract Services - Business Office	20,635	Senior Living Properties, LLC	100.00%	28,056	7,421	5
6	V	17	Contract Services - Administrator	85,890	Senior Living Properties, LLC	100.00%	89,761	3,871	6
7	V	24	Travel	4,231	Senior Living Properties, LLC	100.00%	6,615	2,384	7
8	V	21	Business Meals	171	Senior Living Properties, LLC	100.00%	385	214	8
9	V	24	Seminars	10	Senior Living Properties, LLC	100.00%	126	116	9
10	V	21	Office Supplies	2,163	Senior Living Properties, LLC	100.00%	2,480	317	10
11	V	21	Supplies	2,063	Senior Living Properties, LLC	100.00%	2,124	61	11
12	V	21	Postage	495	Senior Living Properties, LLC	100.00%	507	12	12
13	V	21	Telephone	10,043	Senior Living Properties, LLC	100.00%	10,853	810	13
14	Total			\$ 177,636			\$ 196,072	\$ * 18,436	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	EDP Services	\$	Senior Living Properties, LLC	100.00%	\$ 3,594	\$ 3,594	15
16	V	19	Legal Fees	1,514	Senior Living Properties, LLC	100.00%	9,016	7,502	16
17	V	19	Accounting Fees		Senior Living Properties, LLC	100.00%	14,831	14,831	17
18	V	26	Insurance - General Liability	21,025	Senior Living Properties, LLC	100.00%	23,707	2,682	18
19	V	26	Insurance - Property & Contents	2,494	Senior Living Properties, LLC	100.00%	14,812	12,318	19
20	V	26	Insurance - Other	450	Senior Living Properties, LLC	100.00%	561	111	20
21	V	22	Workers Compensation Claims		Senior Living Properties, LLC	100.00%	3,358	3,358	21
22	V	22	Health & Dental Insurance		Senior Living Properties, LLC	100.00%	11,766	11,766	22
23	V	21	Management Fees		Senior Living Properties, LLC	100.00%	17,515	17,515	23
24	V	19	Legal Fees		Senior Living Properties, LLC	100.00%	363	363	24
25	V	22	Workers Compensation Claims		Senior Living Properties, LLC	100.00%	34,372	34,372	25
26	V	21	Management Fees		Senior Living Properties, LLC	100.00%	13,019	13,019	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 25,483			\$ 146,914	\$ * 121,431	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number LOCUSTWOOD HEALTH CARE CENTER# 0043588

Report Period Beginning:

01/01/00Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization

Senior Living Properties, LLC

Street Address

3395 North Pine Drive, Suite 102

City / State / Zip Code

Wilson, Wyoming 83014

Phone Number

(307) 739-1209

Fax Number

(307) 739-1217

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	10	Contract Services - RN	Resident Days (IL Only)	675,434	31	\$ 13,034	\$ 17,587	\$ 339	1
2	10	Contract Services - RN	Resident Days (IL Only)	675,434	31	50,078	17,587	1,304	2
3	10	Contract Services - RN	Resident Days (IL Only)	675,434	31	59,476	17,587	1,549	3
4	12	Social Services Consultant	Resident Days (IL Only)	675,434	31	1,475	17,587	38	4
5	17	Contract Services - Business Office	Resident Days (Total)	1,728,555	88	729,382	17,587	7,421	5
6	17	Contract Services - Administrator	Resident Days (IL Only)	675,434	31	148,670	17,587	3,871	6
7	24	Travel	Resident Days (IL Only)	675,434	31	91,552	17,587	2,384	7
8	21	Business Meals	Resident Days (IL Only)	675,434	31	8,225	17,587	214	8
9	24	Seminars	Resident Days (IL Only)	675,434	31	4,452	17,587	116	9
10	21	Office Supplies	Resident Days (IL Only)	675,434	31	12,185	17,587	317	10
11	21	Supplies	Resident Days (IL Only)	675,434	31	2,350	17,587	61	11
12	21	Postage	Resident Days (IL Only)	675,434	31	466	17,587	12	12
13	21	Telephone	Resident Days (IL Only)	675,434	31	31,125	17,587	810	13
14	21	EDP Services	Resident Days (IL Only)	675,434	88	138,040	17,587	3,594	14
15	19	Legal Fees	Resident Days (Total)	1,728,555	88	737,379	17,587	7,502	15
16	19	Accounting Fees	Resident Days (Total)	1,728,555	88	1,457,713	17,587	14,831	16
17	26	Insurance - General Liability	Resident Days (Total)	1,728,555	88	263,635	17,587	2,682	17
18	26	Insurance - Property & Contents	Resident Days (Total)	1,728,555	88	1,210,642	17,587	12,318	18
19	26	Insurance - Other	Resident Days (Total)	1,728,555	88	10,924	17,587	111	19
20	22	Workers Compensation Claims	Resident Days (Total)	1,728,555	88	330,015	17,587	3,358	20
21	22	Health & Dental Insurance	Resident Days (Total)	1,728,555	88	1,156,469	17,587	11,766	21
22	21	Management Fees	Resident Days (Total)	1,728,555	88	1,721,509	17,587	17,515	22
23	19	Legal Fees	Resident Days (IL Only)	675,434	31	13,948	17,587	363	23
24	22	Workers Compensation Claims	Resident Days (IL Only)	675,434	31	1,320,062	17,587	34,372	24
25	TOTALS					\$ 9,512,806	\$	\$ 126,848	25

Facility Name & ID Number LOCUSTWOOD HEALTH CARE CENTER # 0043588 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Senior Living Properties, LLC
Street Address 3395 North Pine Drive, Suite 102
City / State / Zip Code Wilson, Wyoming 83014
Phone Number (307) 739-1209
Fax Number (307) 739-1217

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	21	Management Fees	Resident Days (IL Only)	675,434	31	\$ 500,000	\$	17,587	\$ 13,019	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 500,000	\$		\$ 13,019	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related																		
	Long-Term																		
1	GMAC COMM MORG CORP		X	ACQUISITION	\$11,612.00	2/6/98	\$ 1,656,128	\$ 1,550,322	2/1/08	0.0681	\$ 112,100	1							
2	CCS NOTE		X	ACQUISITION	\$425.00	2/6/98	73,280	73,280	2/6/08	0.0700	9,517	2							
3	SEE ATTACHED		X	ACQUISITION	\$425.00	2/6/98	73,280	73,280	2/6/08	0.0700	9,517	3							
4												4							
5												5							
	Working Capital																		
6	HEALTH CARE FINANCIAL PART	X		WORKING CAPITAL	NONE	2/6/98	42,550	31,127	DEMAND	PRIME + 2%	35,505	6							
7												7							
8												8							
9	TOTAL Facility Related				\$12,462.00		\$ 1,845,238	\$ 1,728,009			\$ 166,639	9							
	B. Non-Facility Related*																		
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$ 1,845,238	\$ 1,728,009			\$ 166,639	15							

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.			\$	20,2531
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	30,5652
3. Under or (over) accrual (line 2 minus line 1).			\$	10,3123
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	20,2534
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	30,5657
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	1995	27,080	8	
	1996	29,606	9	
	1997	30,497	10	
	1998	30,802	11	
	1999	30,565	12	
				FOR OFF USE ONLY
				13 FROM R. E. TAX STATEMENT FOR 1999 \$ 13
				14 PLUS APPEAL COST FROM LINE 5 \$ 14
				15 LESS REFUND FROM LINE 6 \$ 15
				16 AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: **14,355**

B. General Construction Type: Exterior **BRICK** Frame **WOOD** Number of Stories **1**

C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY	94,090	1998	\$ 10,761	1
2					2
3	TOTALS	94,090		\$ 10,761	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	63		1998	1972	\$ 870,846	\$	30	\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Exterior Painting			1998	2,150	430	5	430		968
10	Carpet Extract			1998	3,026	378	8	378		851
11										
12	Signage			1998	464	46	10	46		120
13	Land Improvements (Purchase Price)			1998	4,490	299	15	299		873
14	Replace Water Heater			1999	3,600	360	10	360		720
15	Hot Water Heater, 84 Gallon			1999	4,161	416	10	416		555
16	Storage Shed			1999	1,451	73	20	73		85
17	Storage Shed			1999	750	38	20	38		44
18										
19	Building Improvement			2000	1,302	29	15	29		29
20	Patio Door System			2000	2,637	176	15	176		176
21	Hot Water Heater			2000	7,672	913	7	913		913
22	Condensing Unit			2000	2,265	76	10	76		76
23										
24										
25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
36	TOTAL (lines 4 thru 35)				\$ 904,814	\$ 3,234		\$ 3,234	\$	5,410

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 131,815	\$ 47,839	\$ 47,839	\$	VARIOUS	\$ 134,598	37
38	Current Year Purchases	714	17	17		VARIOUS	17	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	\$ 132,529	\$ 47,856	\$ 47,856	\$		\$ 134,615	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				\$	\$	\$	\$		\$	42
43										43
44										44
45										45
46	TOTALS			\$	\$	\$	\$		\$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 1,048,104	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 51,090	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 51,090	49
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	\$	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 140,025	51

**

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NOT APPLICABLE
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5					NOT APPLICABLE			5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-

9. Option to Buy:
- ☐ YES☒ X NO
- Terms: NOT APPLICABLE*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
☐ YES☒ X NO
16. Rental Amount for movable equipment: \$840Description: DISHWASHER - \$196; COPIER - \$191; SCAFFOLDING TRUCK - \$453
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19			NOT APPLICABLE		19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	\$
13.	/2002	\$
14.	/2003	\$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

☐

☐

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39.3	# of prescrpts			205	5,610		5,815	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): ANCILLARY SVCS	39.2 & 39.3					22,574		22,574	13
14	TOTAL			\$		\$ 205	\$ 28,184		\$ 28,389	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 3,500	\$	1
2	Cash-Patient Deposits	26,980		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 128,323)	238,585		3
4	Supply Inventory (priced at COST)	7,516		4
5	Short-Term Investments			5
6	Prepaid Insurance	4,976		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 281,557	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	10,761		13
14	Buildings, at Historical Cost	886,897		14
15	Leasehold Improvements, at Historical Cost	4,954		15
16	Equipment, at Historical Cost	145,492		16
17	Accumulated Depreciation (book methods)	(140,025)		17
18	Deferred Charges	667,590		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,575,669	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,857,226	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 193,283	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	26,980		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	20,253		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	INTER CO SLP TEXAS	945,810		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,186,326	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,728,009		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,728,009	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,914,335	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,057,109)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,857,226	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (500,876)	1
2	Restatements (describe):		2
3	AUDIT ADJUSTMENTS	(53,128)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (554,004)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(503,105)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (503,105)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,057,109)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 1,590,340	1
2	Discounts and Allowances for all Levels	(364,549)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,225,791	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	120	13
14	Non-Patient Meals	489	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 609	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	OTHER REVENUE	40	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 40	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,226,440	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	362,575	31
32	Health Care	696,211	32
33	General Administration	249,240	33
	B. Capital Expense		
34	Ownership	358,542	34
	C. Ancillary Expense		
35	Special Cost Centers	28,389	35
36	Provider Participation Fee	34,588	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,729,545	40
41	Income before Income Taxes (line 30 minus line 40)**	(503,105)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (503,105)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? EXTENDED If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing	1,676	1,955	20,883	10.68	2
3	Registered Nurses	2,187	2,552	65,036	25.49	3
4	Licensed Practical Nurses	8,441	9,848	137,324	13.94	4
5	Nurse Aides & Orderlies	29,580	34,510	275,558	7.98	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,714	2,000	14,981	7.49	9
10	Activity Assistants					10
11	Social Service Workers	2,022	2,359	23,044	9.77	11
12	Dietician					12
13	Food Service Supervisor	2,311	2,696	17,353	6.44	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,153	13,012	80,207	6.16	15
16	Dishwashers					16
17	Maintenance Workers	2,087	2,435	27,467	11.28	17
18	Housekeepers	8,430	9,835	59,822	6.08	18
19	Laundry	3,342	3,899	21,619	5.54	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	469	547	3,440	6.29	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,690	1,972	12,410	6.29	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	75,102	87,619	\$ 759,144 *	\$ 8.66	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	MONTHLY	\$ 5,206	1.3	35
36	Medical Director	MONTHLY	3,300	9.3	36
37	Medical Records Consultant	MONTHLY	220	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	MONTHLY	2,025	10a.3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	MONTHLY	1,765	11.3	44
45	Social Service Consultant	MONTHLY	1,363	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 13,879		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,445	\$ 50,572	10.3	50
51	Licensed Practical Nurses	594	11,871	10.3	51
52	Nurse Aides	377	5,660	10.3	52
53	TOTAL (lines 50 - 52)	2,416	\$ 68,103		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount		Description	Amount
			\$	Workers' Compensation Insurance	\$ 37,730		IDPH License Fee	\$
				Unemployment Compensation Insurance	10,285		Advertising: Employee Recruitment	10,427
				FICA Taxes	50,942		Health Care Worker Background Check	
				Employee Health Insurance	11,766		(Indicate # of checks performed)	
				Employee Meals			ADVERTISING - PUBLIC RELATIONS	2,544
				Illinois Municipal Retirement Fund (IMRF)*			PROF DUES/LICENSES	672
				OTHER EMPLOYEE BENEFITS	5,682			
TOTAL (agree to Schedule V, line 17, col. 1)			\$					
(List each licensed administrator separately.)								
B. Administrative - Other								
Description			Amount				Less: Public Relations Expense	(2,544)
CONTRACT SERV - ADMINISTRATOR			\$ 85,890				Non-allowable advertising	()
CONTRACT SERV - BUS. OFFICE			20,635				Yellow page advertising	()
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 106,525	TOTAL (agree to Schedule V,	\$ 116,405		TOTAL (agree to Sch. V,	\$ 11,099
(Attach a copy of any management service agreement)				line 22, col.8)			line 20, col. 8)	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
VARIOUS	LEGAL		\$ 1,514			\$	Out-of-State Travel	\$
							In-State Travel	7,903
							Seminar Expense	126
							Entertainment Expense	()
							(agree to Sch. V,	
TOTAL (agree to Schedule V, line 19, column 3)			\$ 1,514	TOTAL	\$		line 24, col. 8)	\$ 8,029
(If total legal fees exceed \$2500 attach copy of invoices.)								

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 12
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 4,728 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 34,588
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? YES Indicate the amount. \$ 489
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? IMMATERIAL
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? NO - MINOR
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees